		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039644

Facility Name: Caseyville Nursing and Rehabilitation Center

Address: 601 W. Lincoln (Number) Caseyville (City) 62232 (Zip Code)

County: St. Clair

Telephone Number: (618) 345-3072 **Fax #** (618) 345-3170

IDPA ID Number: 363952446001

Date of Initial License for Current Owners: 06/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,078	824	4,232	7,134	8
9	SNF/PED					9
10	ICF	30,510	8,042		38,552	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,588	8,866	4,232	45,686	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.22%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 4,232

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	193,374	12,658	3,595	209,627		209,627		209,627			1
2	Food Purchase		207,222		207,222		207,222	(4,108)	203,114			2
3	Housekeeping	126,198	59,706		185,904		185,904	85	185,989			3
4	Laundry	87,414	23,570		110,984		110,984		110,984			4
5	Heat and Other Utilities			120,457	120,457		120,457	1,859	122,316			5
6	Maintenance	95,737	52,518	7,707	155,962		155,962	528	156,490			6
7	Other (specify):*											7
8	**TOTAL General Services**	502,723	355,674	131,759	990,156		990,156	(1,636)	988,520			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,459,334	26,362	5,900	1,491,596		1,491,596	(530)	1,491,066			10
10a	Therapy			462,376	462,376		462,376		462,376			10a
11	Activities	61,188	3,955		65,143		65,143		65,143			11
12	Social Services	40,301			40,301		40,301		40,301			12
13	Nurse Aide Training											13
14	Program Transportation			353	353		353		353			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,560,823	30,317	468,629	2,059,769		2,059,769	(530)	2,059,239			16
	C. General Administration											
17	Administrative	67,971		243,250	311,221		311,221	(127,895)	183,326			17
18	Directors Fees											18
19	Professional Services			50,532	50,532		50,532	17,091	67,623			19
20	Dues, Fees, Subscriptions & Promotions			6,906	6,906		6,906	94	7,000			20
21	Clerical & General Office Expenses	257,713		26,999	284,712		284,712	68,547	353,259			21
22	Employee Benefits & Payroll Taxes			337,309	337,309		337,309	3,640	340,949			22
23	Inservice Training & Education											23
24	Travel and Seminar			920	920		920	78	998			24
25	Other Admin. Staff Transportation			23,733	23,733		23,733	265	23,998			25
26	Insurance-Prop.Liab.Malpractice			30,355	30,355		30,355	1,258	31,613			26
27	Other (specify):* **Mgt Alloc-Benefits**							13,673	13,673			27
28	**TOTAL General Administration**	325,684		720,004	1,045,688		1,045,688	(23,249)	1,022,439			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,389,230	385,991	1,320,392	4,095,613		4,095,613	(25,415)	4,070,198			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center #0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			17,651	17,651		17,651	340,600	358,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,879	32,879		32,879	394,460	427,339			32
33	Real Estate Taxes							84,433	84,433			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicles			13,096	13,096		13,096	1,391	14,487			35
36	Other (specify):* Mortgage Insurance							32,047	32,047			36
37	**TOTAL Ownership**			783,626	783,626		783,626	132,931	916,557			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,648	362	99,010		99,010		99,010			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):* Nonallowable Costs			87,266	87,266		87,266	(87,266)				43
44	**TOTAL Special Cost Centers**		98,648	169,978	268,626		268,626	(87,266)	181,360			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,389,230	484,639	2,273,996	5,147,865		5,147,865	20,250	5,168,115			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	40,234	30		9
10	Interest and Other Investment Income	(46)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(486)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(74,210)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,670)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(168)	43		28
29	Other-Attach Schedule See Schedule 5A	(51,765)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,111)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	109,361		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 109,361		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 20,250		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehabilitation Center
Provider #: 0039644
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Legal	(8,000)	19
Office Expense	(1,154)	21
Lab Expense - Med A	(6,205)	43
X-ray Expense - Med A	(3,527)	43
Related Party Interest	(32,879)	32
	(51,765)	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Caseyville Property LLC	100.00%	$ 5,400	$ 5,400	1
2	V	30	Depreciation		Caseyville Property LLC	100.00%	296,817	296,817	2
3	V	32	Interest		Caseyville Property LLC	100.00%	426,215	426,215	3
4	V	33	Real Estate Taxes		Caseyville Property LLC	100.00%	80,524	80,524	4
5	V	34	Rent	720,000	Caseyville Property LLC	100.00%		(720,000)	5
6	V	36	Mortgage Insurance		Caseyville Property LLC	100.00%	32,047	32,047	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 720,000			$ 841,003	$ * 121,003	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehab
Provider # 0039644
12/31/2004

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis
Out-of-State:	
St. Elizabeth Healthcare Center	Florissant, MO

Other Related Business Entities		
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S.W. Management Co.	100.00%	$ 45	$ 45	15
16	V	3	Housekeeping		S.W. Management Co.	100.00%	85	85	16
17	V	5	Utilities		S.W. Management Co.	100.00%	1,859	1,859	17
18	V	6	Maintenance		S.W. Management Co.	100.00%	528	528	18
19	V	17	Administrative - Salaries	183,250	S.W. Management Co.	100.00%	55,355	(127,895)	19
20	V	19	Professional Services		S.W. Management Co.	100.00%	19,691	19,691	20
21	V	20	Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	94	94	21
22	V	21	Clerical - Salaries		S.W. Management Co.	100.00%	64,420	64,420	22
23	V	21	Clerical & General Office Exp.		S.W. Management Co.	100.00%	5,523	5,523	23
24	V	24	Travel and Seminar		S.W. Management Co.	100.00%	78	78	24
25	V	25	Other Admin. Staff Transport.		S.W. Management Co.	100.00%	265	265	25
26	V	26	Insurance-Prop, Liab & Malp.		S.W. Management Co.	100.00%	1,258	1,258	26
27	V	27	Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	13,673	13,673	27
28	V	30	Depreciation		S.W. Management Co.	100.00%	3,549	3,549	28
29	V	32	Interest		S.W. Management Co.	100.00%	1,170	1,170	29
30	V	33	Real Estate Taxes		S.W. Management Co.	100.00%	3,909	3,909	30
31	V	35	Rent-Equipment & Vehicles		S.W. Management Co.	100.00%	1,391	1,391	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 183,250			$ 172,893	$ * (10,357)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 6,376	S & E Medical Supply Co.	100.00%	$ 5,621	$ (755)	15
16	V	3	Housekeeping	7,624	S & E Medical Supply Co.	100.00%	7,624		16
17	V	10	Medical Supplies	3,432	S & E Medical Supply Co.	100.00%	2,902	(530)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,432			$ 16,147	$ * (1,285)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Cente # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.50	Salary	$ 55,355	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	3.5	8.75	Salary&Fees	65,452	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	4.2	10.50	Salary	17,237	L21,C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 138,044		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Caseyville Nursing and Rehab
provider # 0039644
12/31/2004
Sheldon Wolfe **Schedule 7A**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3	$ 55,355		$ 55,355
Caseyville Nursing and Rehab	3	55,355		55,355
Franklin Grove Nursing Center	3	55,355		55,355
Kenwood Healthcare Center	12	221,421		221,421
Oregon Healthcare Center	3	55,355		55,355
Shabbona Healthcare Center	4	73,807		73,807
Tower Hill Healthcare Center	4	73,807		73,807
Virgil Calvert Nursing and Rehab	3	55,355		55,355
St. Elizabeth Healthcare Center	1	18,452		18,452
Other	4	73,807		73,807
	40	$ 738,071		$ 738,071

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehab
provider # 0039644
12/31/2004
Ronnie Klein **Schedule 7B**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3.5	$ 5,452	$ 60,000	$ 65,452
Caseyville Nursing and Rehab	3.5	5,452	60,000	65,452
Franklin Grove Nursing Center	5	7,788	90,000	97,788
Kenwood Healthcare Center	20	31,154	210,000	241,154
Oregon Healthcare Center	3.5	5,452	60,000	65,452
Shabbona Healthcare Center	0	-		-
Tower Hill Healthcare Center	0	-		-
Virgil Calvert Nursing and Rehab	4	6,231	60,000	66,231
St. Elizabeth Healthcare Center	0.5	779		779
Other	0	-		-
	40	$ 62,307	$ 540,000	$ 602,307

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehab
provider # 0039644
12/31/2004
Moshe Herman **Schedule 7C**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	4.2	$ 17,237		$ 17,237
Caseyville Nursing and Rehab	4.2	17,237		17,237
Franklin Grove Nursing Center	3.4	13,954		13,954
Kenwood Healthcare Center	8.8	36,115		36,115
Oregon Healthcare Center	2.8	11,491		11,491
Shabbona Healthcare Center	2.5	10,260		10,260
Tower Hill Healthcare Center	5.7	23,393		23,393
Virgil Calvert Nursing and Rehab	4.2	17,237		17,237
St. Elizabeth Healthcare Center	4.2	17,237		17,237
Other	0	-		-
	40	$ 164,160		$ 164,160

SEE ACCOUNTANTS' COMPILATION REPORT

s

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SW Management Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	527,040	9	$ 429	$	54,900	$ 45	1
2	3	Housekeeping	Bed Days Available	527,040	9	820		54,900	85	2
3	5	Utilities	Bed Days Available	527,040	9	17,851		54,900	1,859	3
4	6	Maintenance	Bed Days Available	527,040	9	5,071		54,900	528	4
5	19	Professional Services	Bed Days Available	527,040	9	189,030		54,900	19,691	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	527,040	9	900		54,900	94	6
7	21	Clerical - Salaries	Bed Days Available	527,040	9	566,095	566,095	54,900	58,968	7
8	21	Clerical & General Office Exp.	Bed Days Available	527,040	9	53,023		54,900	5,523	8
9	24	Travel and Seminar	Bed Days Available	527,040	9	750		54,900	78	9
10	25	Other Admin. Staff Transport.	Bed Days Available	527,040	9	2,548		54,900	265	10
11	26	Insurance-Prop, Liab & Malp.	Bed Days Available	527,040	9	12,072		54,900	1,258	11
12	27	Mgmt. Allocation of Benefits	Bed Days Available	527,040	9	131,259		54,900	13,673	12
13	32	Interest	Bed Days Available	527,040	9	11,228		54,900	1,170	13
14	33	Real Estate Taxes	Bed Days Available	527,040	9	37,528		54,900	3,909	14
15	35	Rent-Equipment & Vehicles	Bed Days Available	527,040	9	13,358		54,900	1,391	15
16										16
17	17	Administrative - Salaries	Avg. Hours Worked	40	9	738,071	738,071	3	55,355	17
18	21	Clerical - Salaries	Avg. Hours Worked	40	7	62,307	62,307	4	5,452	18
19										19
20	30	Depreciation	Direct Cost						3,549	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,842,340	$ 1,366,473		$ 172,893	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 5,621	1
2	3	Housekeeping	Direct Cost						7,624	2
3	10	Medical Supplies	Direct Cost						2,902	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 16,147	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage	$38,896.00	11/27/01	$ 6,814,400	$ 6,646,790	12/01/36	0.0635	$ 422,358	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/P - Stockholders	X		Working capital	$16,579.84			494,334	Demand	Variable	19,573	6
7	Intercompany loan	X		Working capital					Demand	0.0600	13,306	7
8												8
9	TOTAL Facility Related				$55,475.84		$ 6,814,400	$ 7,141,124			$ 455,237	9
	B. Non-Facility Related*											
10							Interest income offset				(965)	10
11							Amortization of mortgage costs				4,776	11
12							Related Party Interest				(32,879)	12
13							SW Management Allocation - Mortgage				1,170	13
14	TOTAL Non-Facility Related						$	$			$ (27,898)	14
15	TOTALS (line 9+line14)						$ 6,814,400	$ 7,141,124			$ 427,339	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 32,047 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 76,767	1
	Management Co. Allocation	3,909	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 77,291	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,433	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 80,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 84,433	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	64,007	8
	2000	65,232	9
	2001	71,322	10
	2002	73,112	11
	2003	77,291	12

2004 Accrual = 77,291 x 1.04 = 80,383
Use 80,000

SW Management allocation = $3,909

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Caseyville Nursing and Rehabilitation Cente COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039644

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-07.0-300-005	Long-term care property	$ 77,291.00	$ 77,291.00
2.	10-28-412-049-0000	SW Management allocation	$ 38,970.00	$ 3,909.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 116,261.00	$ 81,200.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care		2001	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2001	2001	$ 5,265,178	$		$ 146,725	$ 146,725	$ 445,752	4
5											5
6											6
7	Management Allocation		1995		45,087		39	1,288	1,288	12,437	7
8											8
	Improvement Type**										
9	Various			1994	22,302	234	20	1,114	880	11,422	9
10	Various			1995	52,604	107	20	2,631	2,524	25,030	10
11	Various			1996	2,492		20	125	125	1,186	11
12	Various			1997	11,349	43	20	567	524	4,259	12
13	Various			1998	14,511	227	20	726	499	5,570	13
14	Various			1999	83,394	613	20	4,170	3,557	23,000	14
15	Parking Lot			2000	2,830	196	20	142	(54)	614	15
16	Sprinkler System			2000	3,385	87	20	169	82	790	16
17	Sprinkler System			2000	5,820	149	20	291	142	1,382	17
18	A/C Repairs			2000	1,018		10	102	102	468	18
19	Ac Repairs			2000	1,102		20	55	55	252	19
20	Draperies			2000	1,052		20	53	53	224	20
21	Carpeting			2000	1,578		20	79	79	369	21
22	Air Handler			2000	1,786		20	89	89	402	22
23	Air Conditioner			2000	1,963		7	280	280	623	23
24	Air Handler			2000	1,241		20	62	62	279	24
25	Air Conditioner			2000	1,029		20	51	51	239	25
26	Compressor			2000	1,800		20	90	90	450	26
27	Booster Heater			2000	1,675		20	84	84	420	27
28	Air Conditioner			2000	5,821		20	291	291	1,261	28
29	Air Conditioner			2000	17,320		20	866	866	3,969	29
30	Air Conditioner			2001	3,630		20	182	182	666	30
31	Air Conditioner			2001	3,630		20	182	182	666	31
32	Air Conditioner			2001	3,111		20	156	156	571	32
33	Blinds			2001	1,212		20	61	61	233	33
34	Sprinkler Repair			2001	1,609		20	80	80	308	34
35	Sprinkler Heads			2001	2,145		20	107	107	393	35
36	Pipes Repair			2001	1,903		20	95	95	293	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dining Room Wall	2002	$ 10,650	$ 273	10	$ 1,065	$ 792	$ 2,840	37
38	Water Heater	2002	4,900		12	408	408	1,191	38
39	Circuit Breaker	2002	1,390		10	139	139	394	39
40	Air Conditioners	2002	2,890		7	413	413	998	40
41	Air Conditioners	2002	4,284		7	612	612	1,530	41
42	Water Heater	2002	2,249		12	187	187	406	42
43	Doors	2003	9,995	256	20	500	244	1,000	43
44	Dry Value System	2003	5,623	144	20	281	137	445	44
45	Landscaping	2003	8,800	847	20	440	(407)	587	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	1,896	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	170	47
48	P.A. Amplifier	2003	713		20	36	36	72	48
49	Security Systems	2004	23,268	465	20	582	117	582	49
50	16 Transmitters	2004	1,517	152	20	38	(114)	38	50
51	Nurses Stations	2004	35,000	700	20	875	175	875	51
52	Wardrobe units w/ Installation	2004	46,731	935	20	1,168	233	1,168	52
53									53
54									54
55	Allocation from SW management - leasehold improvements	1995	4,810		20	241	241	2,662	55
56	Allocation from SW management - leasehold improvements	1996	840		20	42	42	360	56
57	Allocation from SW management - leasehold improvements	1997	1,210		20	61	61	603	57
58	Allocation from SW management - leasehold improvements	1998	833		20	42	42	281	58
59	Allocation from SW management - leasehold improvements	1999	2,313		20	116	116	588	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,768,287	$ 5,428		$ 169,994	$ 164,566	$ 562,214	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,016,745	$ 10,361	$ 185,480	$ 175,119	10-20	$ 600,078	71
72	Current Year Purchases	15,867	1,862	1,018	(844)	10-20	1,018	72
73	Fully Depreciated Assets							73
74	Allocation of SW Management	11,644		1,155	1,155		9,918	74
75	TOTALS	$ 1,044,256	$ 12,223	$ 187,653	$ 175,430		$ 611,014	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation of SW Mgmt.	2004 Cadillac	2004	$ 6,038	$	$ 604	$ 604	5	$ 604	76
77										77
78										78
79										79
80	TOTALS			$ 6,038	$	$ 604	$ 604		$ 604	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,168,581	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,651	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 358,251	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 340,600	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,173,832	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 8,611 Description: Copier; $8,611
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2002 Chrysler	$ 941.70	$ 4,485	17
18	SW Management allocation			1,391	18
19					19
20					20
21	TOTAL		$ 941.70	$ 5,876	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	14,342	$ 206,097	$	14,342	$ 206,097	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,681	50,804		1,681	50,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		14,994	197,477		14,994	197,477	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				98,648		98,648	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ambulance	L39, C3					362		362	13
14	TOTAL			$	31,017	$ 454,378	$ 99,010	31,017	$ 553,388	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 70,186	$ 202,957	1
2	Cash-Patient Deposits	17,696	17,696	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,044,651	1,044,651	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,233	51,972	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	186,960	388,076	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,339,726	$ 1,705,352	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,265,179	14
15	Leasehold Improvements, at Historical Cost	196,945	503,108	15
16	Equipment, at Historical Cost	393,701	1,050,294	16
17	Accumulated Depreciation (book methods)	(396,876)	(1,173,832)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See Sch. 17A		152,692	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 193,770	$ 6,147,441	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,533,496	$ 7,852,793	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 97,656	$ 101,158	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,243	22,243	28
29	Short-Term Notes Payable	494,334	494,334	29
30	Accrued Salaries Payable	117,941	117,941	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,327	14,327	31
32	Accrued Real Estate Taxes(Sch.IX-B)		80,000	32
33	Accrued Interest Payable	1,805	94,683	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	539,202	527,179	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,287,508	$ 1,451,865	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,646,790	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,646,790	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,287,508	$ 8,098,655	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 245,988	$ (245,862)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,533,496	$ 7,852,793	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Caseyville Nursing and Rehabilitation Center
Provider #: 0039644
12/31/04

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Insurance Escrow		17,234
MIP Escrow		310
Replacement reserve		157,807
Real estate tax escrow		25,765
Short term loan exchange	128,543	128,543
Prior owner balance	58,417	58,417
Total Line 9 - Other Current Assets (specify):	**186,960**	**388,076**

Other Long-Term Assets (specify):	Operating	After Consolidation
Mortgage Costs	0	167,434
Accumulated Amortization	0	(14,742)
Total Line 22 - Other Long-Term Assets (specify)	**0**	**152,692**

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	1,271	1,271
Accrued retirement	(450)	(450)
Accrued expenses	135,492	135,492
Due to Caseyville Properties	12,023	
Short Term Loan Exchange	390,866	390,866
Total Line 36 - Other Current Liabilities (specify):	**539,202**	**527,179**

See Accountants' Compilation Report

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 100,317	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 100,317	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,671	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 145,671	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 245,988	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,902,405	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,902,405	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	379,676	6
7	Oxygen	9,273	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 388,949	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,200	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,200	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	982	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 982	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,293,536	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	990,156	31
32	Health Care	2,059,769	32
33	General Administration	1,045,688	33
	B. Capital Expense		
34	Ownership	783,626	34
	C. Ancillary Expense		
35	Special Cost Centers	186,276	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,147,865	40
41	**Income before Income Taxes (line 30 minus line 40)****	145,671	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 145,671	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity is a cash basis taxpayer.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,080	$ 52,889	$ 25.43	1
2	Assistant Director of Nursing	1,984	2,080	47,758	22.96	2
3	Registered Nurses	2,431	2,652	60,119	22.67	3
4	Licensed Practical Nurses	22,831	24,414	483,171	19.79	4
5	Nurse Aides & Orderlies	74,764	79,300	741,922	9.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,055	6,853	73,475	10.72	8
9	Activity Director					9
10	Activity Assistants	5,268	5,779	61,188	10.59	10
11	Social Service Workers	3,057	3,307	40,301	12.19	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,080	33,086	15.91	13
14	Head Cook	9,785	10,592	97,449	9.20	14
15	Cook Helpers/Assistants	8,041	8,449	62,839	7.44	15
16	Dishwashers					16
17	Maintenance Workers	5,552	5,855	95,737	16.35	17
18	Housekeepers	15,303	16,339	126,198	7.72	18
19	Laundry	10,907	11,772	87,414	7.43	19
20	Administrator	1,880	2,080	67,971	32.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,113	12,130	257,713	21.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,771	195,762	$ 2,389,230 *	$ 12.20	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 3,595	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	5,900	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	96	7,998	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	$ 17,493		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Geralyn Isenbeg	Administrator	0	$ 67,971
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,971

B. Administrative - Other

Description	Amount
SW Management fees	$ 60,000
Sw Management - Home Office	123,250
Ronnie Klein - Management fees	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 243,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Burroughs, Hepler, Broom	Legal	25,438
Ashman & Stein	Legal	1,904
Winston & Strawn	Legal	736
Frost, Ruttenberg & Rothblatt	Accounting	13,523
Personell planners	Unemployment Consultant	931
Sachnoff & Weaver	Legal	8,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,532

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,158
Unemployment Compensation Insurance	38,119
FICA Taxes	183,027
Employee Health Insurance	53,852
Employee Meals	3,398
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	
Employee Morale	5,395
TOTAL (agree to Schedule V, line 22, col.8)	$ 340,949

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 217)	2,605
Illinois Council on Long Term Care	2,700
Permits	150
Dues and Subscriptions	251
Licenses	1,200
Allocated from SW Management	94
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,000

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	920
Allocated from SW Management	78
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 998

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing and Rehabilitation Center
Provider #: 0039644
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	50,532
Allocated from Caseyville Properties, LLC	
Legal	1,900
Accounting - Frost, Ruttenberg & Rothblatt	3,500
Allocated from Management Company	
Legal	18,983
Accounting - Frost, Ruttenberg & Rothblatt	708
Professional Services Disallowed	(9,959)
Total (agree to Schedule V, line 19, column 8)	65,664

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing and Rehabilitation Center # 0039644 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care-2700**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
n/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **3,398** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	193,374	12,658	3,595	209,627	0	209,627	0	209,627
2. Food Purchase	0	207,222	0	207,222	0	207,222	-4,108	203,114
3. Housekeeping	126,198	59,706	0	185,904	0	185,904	85	185,989
4. Laundry	87,414	23,570	0	110,984	0	110,984	0	110,984
5. Heat and Other Utilities	0	0	120,457	120,457	0	120,457	1,859	122,316
6. Maintenance	95,737	52,518	7,707	155,962	0	155,962	528	156,490
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	502,723	355,674	131,759	990,156	0	990,156	-1,636	988,520
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	1,459,334	26,362	5,900	1,491,596	0	1,491,596	-530	1,491,066
10a. Therapy	0	0	462,376	462,376	0	462,376	0	462,376
11. Activities	61,188	3,955	0	65,143	0	65,143	0	65,143
12. Social Services	40,301	0	0	40,301	0	40,301	0	40,301
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	353	353	0	353	0	353
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,560,823	30,317	468,629	2,059,769	0	2,059,769	-530	2,059,239
17. Administrative	67,971	0	243,250	311,221	0	311,221	-127,895	183,326
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	50,532	50,532	0	50,532	17,091	67,623
20. Fees, Subscriptions & Promotion	0	0	6,906	6,906	0	6,906	94	7,000
21. Clerical & General Office	257,713	0	26,999	284,712	0	284,712	68,547	353,259
22. Employee Benefits & Payroll	0	0	337,309	337,309	0	337,309	3,640	340,949
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	920	920	0	920	78	998
25. Other Admin. Staff Trans	0	0	23,733	23,733	0	23,733	265	23,998
26. Insurance-Prop.Liab.Malpractice	0	0	30,355	30,355	0	30,355	1,258	31,613
27. Other (specify)*	0	0	0	0	0	0	13,673	13,673
28. Total General Adminis	325,684	0	720,004	1,045,688	0	1,045,688	-23,249	1,022,439
29. Total General Administrative	2,389,230	385,991	1,320,392	4,095,613	0	4,095,613	-25,415	4,070,198
30. Depreciation	0	0	17,651	17,651	0	17,651	340,600	358,251
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	32,879	32,879	0	32,879	394,460	427,339
33. Real Estate	0	0	0	0	0	0	84,433	84,433
34. Rent - Facility & Grounds	0	0	720,000	720,000	0	720,000	-720,000	0
35. Rent - Equipment & Vehicles	0	0	13,096	13,096	0	13,096	1,391	14,487
36. Other (specify):*	0	0	0	0	0	0	32,047	32,047
37. Total Ownership	0	0	783,626	783,626	0	783,626	132,931	916,557
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	98,648	362	99,010	0	99,010	0	99,010
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	82,350	82,350	0	82,350	0	82,350
43. Other (specify):*	0	0	87,266	87,266	0	87,266	-87,266	0
44. Total Special Cost Ce	0	98,648	169,978	268,626	0	268,626	-87,266	181,360
45. Grand Total	2,389,230	484,639	2,273,996	5,147,865	0	5,147,865	20,250	5,168,115

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	70,186	202,957
2. Cash - Patient Deposits	17,696	17,696
3. Accounts & Notes Recievable	1,044,651	1,044,651
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	20,233	51,972
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	186,960	388,076
10. Total current assets	1,339,726	1,705,352
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	350,000
14. Buildings, at Historical Cost	0	5,265,179
15. Leasehold Improvements, Historical Cost	196,945	503,108
16. Equipment, at Historical Cost	393,701	1,050,294
17. Accumulated Depreciation (book methods)	-396,876	-1,173,832
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	152,692
23. other (specify):	0	0
24. Total Long-Term Assets	193,770	6,147,441
25. Total Assets	1,533,496	7,852,793
CURRENT LIABILITIES		
26. Accounts Payable	97,658	101,158
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	22,243	22,243
29. Short-Term Notes Payable	494,334	494,334
30. Accrued Salaries Payable	117,941	117,941
31. Accrued Taxes Payable	14,327	14,327
32. Accrued Real Estate Taxes	0	80,000
33. Accrued Interest Payable	1,805	94,683
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	539,202	527,179
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,287,510	1,451,865
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	6,646,790
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	6,646,790
46.Total Liabilities	1,287,510	8,098,655
47.Total Equity	245,986	-245,862
48.Total Liabilities and Equity	1,533,496	7,852,793

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	4,902,405
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	4,902,405
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	379,676
7. Oxygen	9,273
Subtotal - Anciliary Revenue	388,949
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	1,200
Subtotal - Non-Operating Revenue	1,200
27. Other Revenue (specify):	982
28. Other Revenue (specify):	0
Subtotal - Other Revenue	982
30. Total Revenue	5,293,536
31. General Services	990,156
32. Health Care	2,059,769
33. General Administration	1,045,688
34. Ownership	783,626
35. Special Cost Centers	186,276
35. Provider Participation Fee	82,350
37. Other	0
40. Total Expenses	5,147,865
41. Income Before Income Taxes	145,671
42. Income Taxes	0
43. Net Income or Loss for the Year	145,671